CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
March 21, 2022
12 to 2:00p

As the elected leadership of the CCRMC/HCs Medical Staff, we stand against racism and hate. *We recognize the negative impact of longstanding structural racism on health, and we commit to take action to combat this in our own system and work for health equity for our patients.*

Join Zoom Meeting
https://cchealth.zoom.us/j/8544948118
Meeting ID: 854 494 8118
****If you are on phone only for the Zoom, use *6 to mute/unmute**

Agenda Topic	Status	Time
Call to Order		
Review of February 28, 2022 Minutes	See attached Draft Minutes.	2 min.
Announcements (3 min)		

- **April 18, 2022 MEC meeting reports to Sue by April 7, 2022**
  - Medical Staff Assistance Committee
  - CCHP Health Plan-Sharron Mackey
  - Department of Hospital Medicine-Dr. Beach
  - MERP – Dr. Ataii
  - Diagnostic Imaging-Dr. Liebig
  - Cancer Committee-Dr. Gynn
  - Emergency Medicine-Dr. Aarden
  - FNP/NP-Heather Cedermaz
  - Surgery Department-Dr. Dosanjh
  - Administrative Affairs Committee-Drs. Robello & Tyrrel
  - Utilization Review Committee-Dr. Rael
  - Inpatient Psychiatry-Dr. Bhandari

Please use the standard SBAR form for your reports -You will be given 5 minutes in which to present your report. **PLEASE DATE YOUR REPORT AND NUMBER THE PAGES. Be sure to include your executive summary which can be added to the minutes. Next meeting April 18, 2022**

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
March 21, 2022
12 to 2:00p

Agenda Topic	Status	Time
ADMINISTRATIVE REPORTS		
Anna Roth, Health Services Director Ori Tzvieli, Health Officer, Director of Public Health Pat Godley, CFO for Health Services Gilbert Salinas, Chief Equity Officer, HS Jaspreet Benepal, RN, Chief Nursing Officer Samir Shah, M.D., Chief Executive Officer/Chief Medical Officer Vacant - Chief Quality Officer David Runt - Chief Operations Officer	Rajiv Pramanik, M.D.- CMIO Gabriela Sullivan, M.D.- Specialty/Ambulatory Medical Director Sergio Urcuyo, M.D.- Hospital Medical Director Sonia Sutherland, M.D.-Medical Director, Detention Health Sharron Mackey, MHS, Chief Executive Officer CCHP Dennis Hsieh, M.D., Medical Director/CMO CCHP	
NEW BUSINESS		
Department of Health Equity	Gilbert Salinas	5 min.
Funding Requests for 2022-2023 have been sent out-see your email-Due to Sue April 7	Dr. Forman	3 min.
Ballots for Department Heads have been sent out-due April 11th	Dr. Forman	2 min.
Approve $10,500.00 Doctors' Day Gifts	Dr. Forman	3 min.
Approve Dr. Veda Bhatt as Chair of the Medical Staff Assistance Committee-Vote Needed	Dr. Forman	3 min.
CCHS Wellness Presentation	Dr. Sutherland & Dr. Johnson	5 min.
OLD BUSINESS		
Bylaws go to Board of Supervisors on 3-22-22 for approval.	Dr. Forman	3 min.
Consent Agenda		
Medication Safety Committee-Dr. Ataii	See report.	5 min.
PCP&E-Dr. Forman Policy 410: Confidentiality Agreement for Non-Medical Staff Members & Other Personnel Associated with Medical Staff, Peer Review, Committees or Activities	See report. Please ask if you wish to see a specific policy and it will be sent to you.	5 min.
COMMITTEE REPORTS		
Credentials Committee- Dr. Mbanugo List of Candidates - Vote needed	See report.	3 min.

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA
CHAIR-KRISTIN MOELLER, M.D.
March 21, 2022
12 to 2:00p

Agenda Topic	Status	Time
Patient Safety and Performance Improvement Committee - Dr. Beach	No report this month.	3 min.
APC - Dr. Pyrkova **AC Nursing Policy 4045 Outpatient Diagnostic Hysteroscopy**	See report.	3 min.
Contra Costa Health Plan-Sharron Mackey	Pending	5 min.
DEPARTMENT & DIVISION REPORTS		
Psychiatry/Psychology Department-Dr. Guss	See report.	5 min.
Diagnostic Imaging-Dr. Liebig	Pend to April.	5 min.
Pathology Department-Dr.Das	Pending.	5 min.
Surgery Peer Review	See report	5 min.
ADJOURN TO CLOSED SESSION-VOTING MEMBERS ONLY		
Adjournment. Next Meeting Date: April 18, 2022		

CONFIDENTIALITY AGREEMENT FOR NON-MEDICAL STAFF MEMBERS AND OTHER PERSONNEL ASSOCIATED WITH MEDICAL STAFF, PEER REVIEW, COMMITTEES OR ACTIVITIES

I. PURPOSE:

To establish an atmosphere of confidentiality to ensure adequate exchange of information in quality assurance and peer review activities.

II. REFERENCES:

Evidence Code, 1157
CCRMC/HCs Policy & Procedure Manual, Policy No. 700 Policy on Confidentiality of Patient Information.

III. POLICY:

Effective peer and quality review require support from staff individuals who are not medical staff members. It is imperative that these activities be based on free and candid discussion. For that reason, the same standards of confidentiality mandated by the medical staff by-laws shall be extended and in effect for non-medical staff engaging/supporting the same activities. Any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, committees, or activities except in conjunction with other hospital, professional society, or licensing authority is outside appropriate standards of conduct.

IV. AUTHORITY/RESPONSIBILITY:

Manager, Medical Staff Coordinators and Clerks of the Medical Staff Office (MSO);Utilization Review Coordinators – Quality, Quality Management Program Coordinators; other personnel as appropriate.

V. PROCEDURE:

A. Non-medical staff employees who provide support to medical staff departments, committees, and/or activities engaged in medical staff quality assurance or peer review activities will be required to sign an attestation (see attachment) committing to confidentiality. The departments, committees, and/or activities include the following but are not limited to:
   1. Patient Safety and Performance Improvement Committee
   2. All Medical Staff Department and Division Meetings
   3. Risk Management Committee
   4. Perinatal Morbidity and Mortality Committee
   5. Quality Management Department Meetings.
   6. Bio-Ethics Committee.
   7. Medical Quality Assurance Committee.
   8. Medical Executive Committee.
   9. Psychiatry Utilization Review.
   10. Cancer Committee.
   11. Critical Care Committee.
   12. Patient Care Policy and Evaluation Committee.

B. Employees are required to sign the "Confidentiality Agreement for Non-Medical Staff

Members and Other Personnel Associated with Medical Staff Peer Review Committees/Activities" form. This form is for:

1. All nursing and ancillary members of the committees listed above including permanent, guest, one-time, or one-issue members;
2. All other personnel associated with Medical Staff, Peer Review Committee Activities; such as case reviewers, abstractors, collectors, and data entry personnel.

C. A signature need only be obtained once. It is the responsibility of the minute taker/staff support person assigned to the committee to obtain signed forms.
D. Completed forms are to be stored with current committee minutes in binder or folder.
E. Individuals violating this agreement are subject to disciplinary action as deemed appropriate including application to accord for injunctive or other legal action.

VI. FORMS:

Confidentiality Agreement

VII. RESPONSIBLE STAFF PERSON

Medical Staff President

REVIEWED/REVISED 5/97; 3/01; 12/2021
MEC APPROVAL 3/15/22
JCC/BOARD APPROVAL

QUALITY MANAGEMENT DEPARTMENT
MEDICAL STAFF PEER REVIEW COMMITTEES
MEDICAL STAFF SUPPORT PERSONNEL

CONFIDENTIALITY AGREEMENT

Confidentiality agreement for non-medical staff members and other personnel associated with medical staff peer review committees or activities.

As a non-medical staff member or guest, or as a support individual to a committee involved in the evaluation and improvement of the quality of care rendered in the hospital and clinics, I recognize that confidentiality is vital to the free and candid discussions necessary for effective medical staff peer review, quality assurance, and other confidential activities. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of medical, nursing, or other ancillary staff affairs.

Furthermore, my participation in peer review, quality assurance, and other confidential activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the medical, nursing, or other ancillary/support staff involved in these activities. I understand the hospital, clinics and the medical staff are entitled to undertake such action as deemed appropriate to ensure that this confidentiality is maintained, including application to a court for injunctive or other relief in the event of a threatened breach of this agreement.

DATE:

NAME:
(Please print name)

SIGNATURE:

OUTPATIENT DIAGNOSTIC HYSTEROSCOPY

I. PURPOSE:

To provide guidelines for the nurse assisting the physician in performing a hysteroscopy in Ambulatory Care.

II. REFERENCES:

Royal College of Obstetricians and Gynaecologists (RCOG), British Society for Gynecological Endoscopy. Best practice in outpatient hysteroscopy. London (UK): Royal College of Obstetricians and Gynaecologists (RCOG); 2011 Mar. 22 p. (Green-top guideline; no. 59).

Linda D. Bradley, Tommaso Falcone. "Hysteroscopy: Office Evaluation and Management of the Uterine Cavity." Elsevier Health Sciences, 2008.

TJC 2016 Standard PC.01.02.15, "The hospital provides for diagnostic testing."

III. POLICY:

Whenever a hysteroscopy is performed in Ambulatory Care, the nurse will have the following equipment and follow the procedure as outlined below.

IV. AUTHORITY/RESPONSIBILITY

RN, LVN

Nursing Staff will be trained on the use of the hysteroscope and procedure. Staff will maintain their clinical skill annually.

V. PROCEDURE

A. Assemble the following equipment and supplies:
   1. 1000mL normal saline for irrigation (1) hanging bag
   2. Tall IV pole
   3. Pressure bag/blood pressure cuff to be place around fluid medium bag to maintain distention
   4. 1% Lidocaine without epinephrine 20cc OR 1% Lidocaine with Epinephrine (20cc). (Physician to decide preference).
   5. 10mL Syringe with control top (2)
   6. 18-gauge needle (1)
   7. 22G Spinal needle (1)
   8. Sterile gloves
   9. GYN Pelvic Kit
   10. Open-sided speculum
   11. Betadine solution
   12. Biopsy forceps for rigid scope graspers and whatever else provider needs or thinks s/he needs.
   13. Light source
   14. Bucket (to catch irrigation fluid) if not using the under-buttock drape with funnel
   15. Chuxs (for floor around bucket) and/or Under Buttock Drape with Funnel

B. Patient Preparation/Education:
   1. Obtain necessary consent.
   2. Have patient empty his/her bladder.
   3. Explain procedure and provide emotional support to the patient.

4. Have patient undress from the waist down
5. Cover patient with sheet.
6. Have patient put feet in stirrups.
7. Assess for allergy to NSAIDs, betadine and lidocaine%.

C. Nursing Functions:
1. Time In and Pre-medicate patient with Ketorolac 30mg IM, or Ibuprofen 600mg PO x 1, or Acetaminophen 650mg X 1, per MD EPIC order.
2. Procedure consent must be signed by the patient prior to taking Narcotics, If Narcotics were prescribed for the procedure by the provider.
3. Place all instruments on sterile field.
4. Hang normal saline for distention with hysteroscopy set (keep tip sterile).
5. Open GYN pelvic set and pour Betadine over gauze.
6. Drop gloves on sterile field when provider is ready to start.
7. Open and drop needles and syringes into sterile pelvic kit field.
8. Hook up light source and Video:
   a. Provider will hand you sterile end.
   b. Turn light source setting per providers preferences
9. Time Out
10. Sign Out.
11. At end of procedure ensure counts correct and that the pathology is correctly labeled.

Check list:
1. Introduction of team members to patient
2. Safety check of monitoring and emergency equipment
3. 2 patient identifiers confirmed
4. Confirmed consent
5. Confirmed procedure
6. Special precautions (e.g., MRSA)
7. Review of test results (pregnancy)
8. Confirmed Allergies
9. Confirmed Medication if any (antibiotics)
10. Any special patient concerns
11. Check sterility indicators
12. Any special instrument or implants
13. Post procedure volume of normal saline used in uterine distension if applicable
14. Specimen labelling and management
15. Any equipment issues

D. Care of scopes after procedure:
1. Rinse/soak scopes as directed by sterile processing and place in soiled utility room for central supply tech to process.
2. Sterile processing to be performed per manufactures instructions

E. Document and charge for procedure in cclink.

The original policy written by Ogo Mbanugo, MD

REVISED AND APPROVED BY APC:
1/2016, 4/2016, 2/2022

REVIEWED AND APPROVED BY:
ACPC: 7/2016
Medical Executive Committee: 8/2016**, 03/2022**

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
April 18, 2022
12 to 2:00p

As the elected leadership of the CCRMC/HCs Medical Staff, we stand against racism and hate. *We recognize the negative impact of longstanding structural racism on health, and we commit to take action to combat this in our own system and work for health equity for our patients.*

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Agenda Topic	Status	Time
Call to Order		
Review of March 21, 2022 Minutes	See attached Draft Minutes.	2 min.
Announcements (3 min)		
• **May, 2022 MEC meeting reports to Sue by May 5, 2022** ○ Critical Care-Dr. Forman ○ DFAM-Dr. Sandler ○ Department of Hospital Medicine-Dr. Beach ○ Medical Staff Assistance Committee-Dr. Bhatt ○ CCHP Health Plan-Sharron Mackey ○ Pathology-Dr. Das ○ Cancer Committee-Dr. Gynn ○ Utilization Review Committee-Dr. Rael Please use the standard SBAR form for your reports -You will be given 5 minutes in which to present your report. **PLEASE DATE YOUR REPORT AND NUMBER THE PAGES. Be sure to include your executive summary which can be added to the minutes. Next meeting May 16, 2022**		
ADMINISTRATIVE REPORTS		
Anna Roth, Health Services Director Ori Tzvieli, Health Officer, Director of Public Health Pat Godley, CFO for Health Services Gilbert Salinas, Chief Equity Officer, HS Jaspreet Benepal, RN, Chief Nursing Officer Samir Shah, M.D., Chief Executive Officer/Chief Medical Officer Vacant - Chief Quality Officer David Runt - Chief Operations Officer	Rajiv Pramanik, M.D.- CMIO Gabriela Sullivan, M.D.- Specialty/Ambulatory Medical Director Sergio Urcuyo, M.D.- Hospital Medical Director Sonia Sutherland, M.D.-Medical Director, Detention Health Sharron Mackey, MHS, Chief Executive Officer CCHP Dennis Hsieh, M.D., Medical Director/CMO CCHP	
NEW BUSINESS		

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA

CHAIR-KRISTIN MOELLER, M.D.
April 18, 2022
12 to 2:00p

Agenda Topic	Status	Time
Financial Report-Dr. Moeller	Dr. Moeller-See report	5 min.
Department Head-Voting Results **ED - Dr Aarden elected** **Critical Care - Dr Elangovan elected** **Psychiatry - Dr Guss elected** **Ob/GYN - Dr C. Wong elected** **DFAM Far East division - Dr David Lee** **DFAM West County - Dr Sheldon** **DI-TBD** **Surgery-Tie Vote**	Dr. Moeller	3 min.
OLD BUSINESS		
		3 min.
Consent Agenda		
Medication Safety Committee-Dr. Ataii	See report	5 min.
PCP&E-Dr. Forman IC502 Sudden Influx of Infectious Patients, Surge Capacity Plan 2021-2022 IC227 Respiratory Hygiene Guidelines IC421 Controlled Air Purifying Respirator 364 Hospital Policy: 364- Code Blue 364C Protected Code Blue 364F Code Blue Workflow in PES Psych Nursing Policy -Helena Martey 403 Overview of the Department of Psychiatry 530 Code Gray and Assistance Calls Hospital Policy -Helena Martey 364 Hospital Policy: 364- Code Blue 364C Protected Code Blue 364F Code Blue Workflow in PES	See report	5 min.
COMMITTEE REPORTS		
Credentials Committee- Dr. Mbanugo List of Candidates - Vote needed	See report	3 min.

CONTRA COSTA HEALTH SERVICES

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MEDICAL EXECUTIVE COMMITTEE AGENDA
CHAIR-KRISTIN MOELLER, M.D.
April 18, 2022
12 to 2:00p

Agenda Topic	Status	Time
Patient Safety and Performance Improvement Committee - Dr. Beach	Oral report	3 min.
APC - Dr. Pyrkova **Policy 4107-Direct Admission to CCRMC**	See report	3 min.
Contra Costa Health Plan-Sharron Mackey	Pending	5 min.
Cancer Committee-Dr. Gynn	Pend to May	5 min.
Administrative Affairs Committee-Drs. Robello & Tyrrel	See report	5 min.
Utilization Review Committee-Dr. Rael	Pend to May	5 min.
DEPARTMENT & DIVISION REPORTS		
Psychiatry/Psychology Department-Inpatient-Dr. Bhandari	See report	5 min.
Diagnostic Imaging-Dr. Liebig	See report	5 min.
Pathology Department-Dr.Das	Pend to May	5 min.
Department of Hospital Medicine-Dr. Beach	Pend to May	5 min.
FNP/NP-Heather Cedermaz	See report	5 min.
ADJOURN TO CLOSED SESSION-VOTING MEMBERS ONLY		
Adjournment. Next Meeting Date: May 16, 2022		

RESPIRATORY HYGIENE GUIDELINES

I. PURPOSE:

To provide guidelines for the implementation of Center for Disease Control and California Department of Health Services' recommendations to limit the spread of communicable respiratory illness within the healthcare setting. The term given to these guidelines is "Respiratory Hygiene."

II. REFERENCES

CAL OSHA, Title 8 Section 5199, Aerosol Transmissible Diseases July 2009

Hospital Infection Control Practices Advisory Committee (HICPAC), Centers for Disease Prevention and Control, "Guidelines for Isolation Precautions in Healthcare Settings," June 2007. (Downloaded 7/5/07)

Department of Health and Human Services, Centers for Disease Control and Prevention, "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings," MMWR, December 30, 2005, Vol. 54 No. RR-17

III. POLICY:

To minimize the transmission risk of communicable respiratory illness in the health care setting, Contra Costa Regional Medical Centers and Health Centers will adopt a series of measures known as "Respiratory Hygiene."

Respiratory Hygiene is comprised of infection control measures aimed at reducing the transmission of respiratory illness (e.g. influenza, colds etc.) by containing droplets at the source where they are produced (nose, mouth) through the use of tissues and masks.

IV. AUTHORITY/RESPONSIBILITY:

Infection Prevention and Control Program Manager
Ambulatory Care Clinical Services Managers
All Emergency Department Personnel
All Health Center Personnel

V. PROCEDURE:

A. Signs will be placed at hospital and clinic entrances encouraging people who are ill with a respiratory illness to cover their mouth and nose when coughing.
   - The signs will encourage persons with fever and cough and/or rash to ask for a mask.

B. At entry, triage or registration, all persons presenting with symptoms of a respiratory illness will be asked to wear a mask. The person will be instructed in the proper use and disposal of the mask after use.
   - CCRMC and CCHC employees are encouraged to ask coughing

persons to wear a mask or cover their cough with tissue.
- Triage and registration personnel will have access to an adequate supply of masks and tissues.
- A supply of masks will be available in publicly accessible areas.
- Trash containers will be located to facilitate appropriate disposal of masks and tissues.

C. Persons who cannot wear a mask will be provided with tissues to cover the nose and mouth when coughing or sneezing. The person will also be instructed in the appropriate disposal of used tissues.
- Designate a specific waiting area or section for these patients.
- Place the patient into a treatment or examination room.

D. Whenever possible, persons with respiratory illness will be physically separated from other patients.
- Minimize the number of areas within the hospital or clinic to which the person must travel.
- Advise ancillary departments to expedite the patient's time within their department.
- Alert the departments that the patient should remain masked.

E. If possible, expedite the person's visit within the Emergency or Ambulatory Care Center. Encourage Handwashing for both staff and patients.
- Increased availability of alcohol based hand gel dispensers.
- Adequate supplies of soap and towels at sink areas.

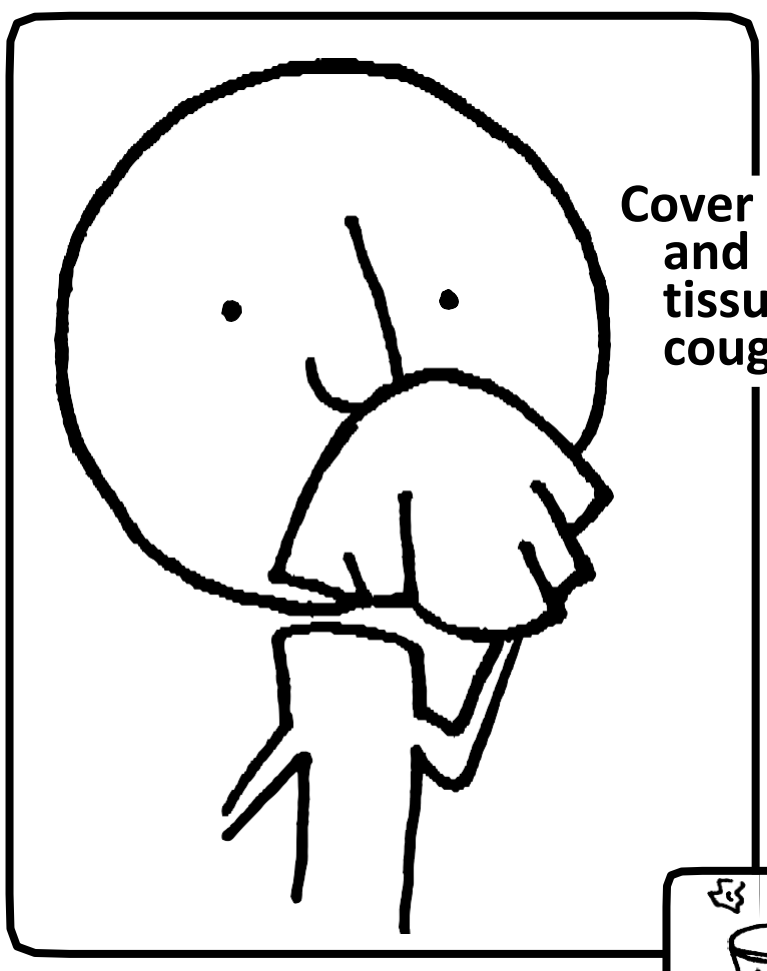
V. DOCUMENTATION:

Sign A Cover your Cough English
Sign B Cover your Cough Spanish

REVIEWED:
6/2008 (new), 6/2013, 8/2017, 2/2022

Stop the spread of germs that make you and others sick!

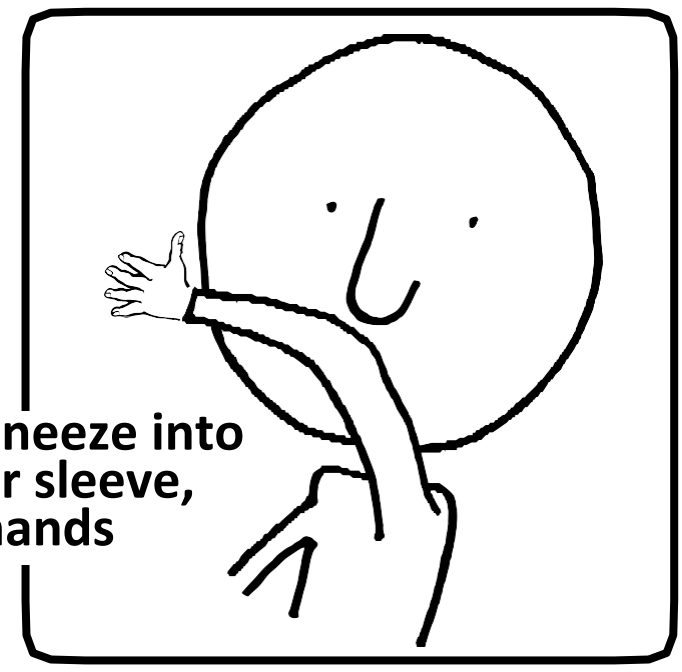
Cover your Cough

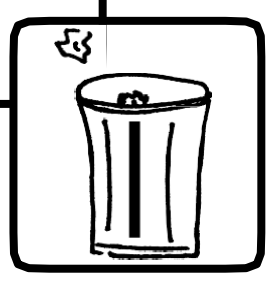


Cover your mouth and nose with a tissue when you cough or sneeze

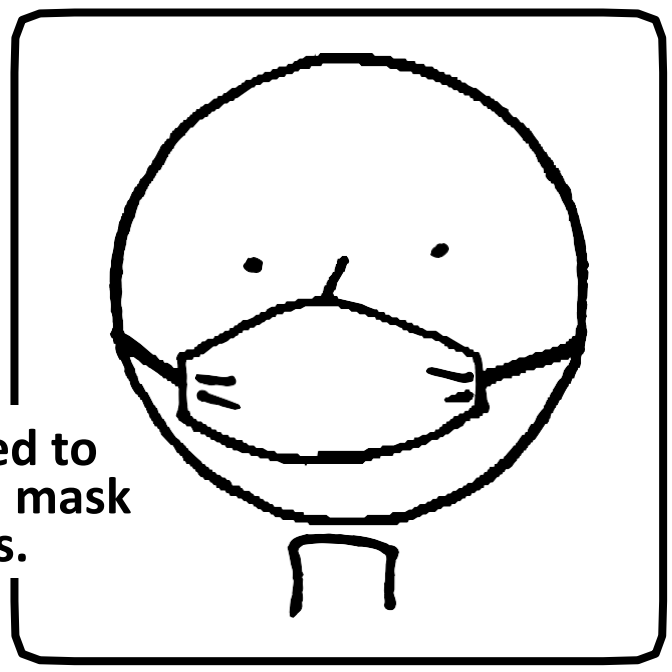
or

cough or sneeze into your upper sleeve, not your hands





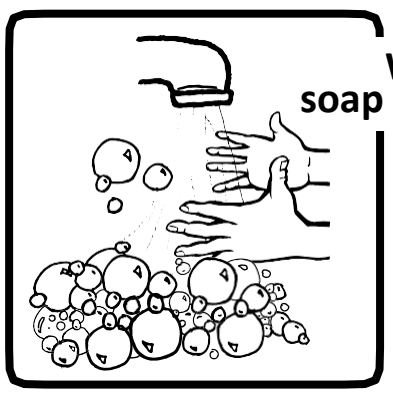
Put your used tissue in the waste basket.



You may be asked to put on a surgical mask to protect others.

Clean your Hands

after coughing or sneezing.



Wash with soap and water

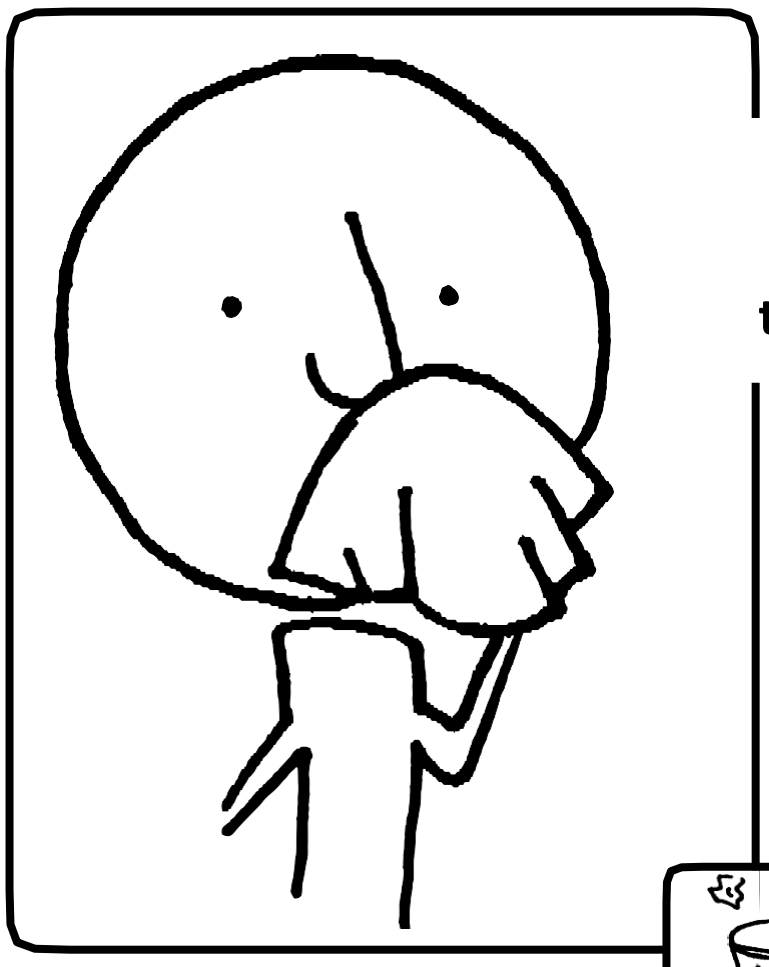
or

clean with alcohol-based hand sanitizer.

CONTRA COSTA
HEALTH SERVICES

¡Pare la propagación de gérmenes que lo enferman a usted y a otras personas!

Cubra su tos

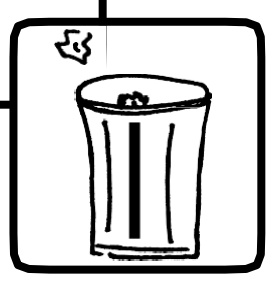


Cubra su boca y nariz con un kleenex cuando tosa o estornude

o

tosa o estornude en la manga de su camisa, no en sus manos.

Deseche el kleenex sucio en un basurero.



Quizás le pidan ponerse una mascarilla quirúrgica para proteger a otras personas.

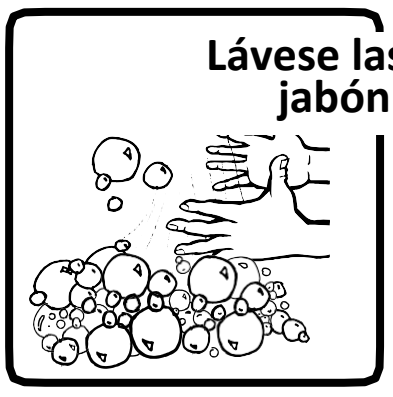
Lávese las manos

después de toser o estornudar

Lávese las manos con jabón y agua tibia

o

límpielas con un limpiador de manos a base de alcohol.



CONTRA COSTA HEALTH SERVICES

CONTROLLED AIR PURIFYING RESPIRATOR (CAPR)

I. PURPOSE:

To provide a higher level of protection for employees who are performing aerosol-generating procedures on a patient with suspected or confirmed illness with an Airborne Transmissible organism.

To provide an alternative to the fit tested N95 respirator for the following persons or situations:

- Employee has facial hair in the mask area that precludes the use of a 95N Respirator
- Employee cannot achieve an adequate fit with a 95N Respirator
- There is a shortage of 95N Respirators

II. REFERENCES:

CAL OSHA, Title 8 Section 5199, Aerosol Transmissible Diseases July 2009

Hospital Infection Control Practices Advisory Committee (HICPAC), Centers for Disease Prevention and Control, "Guidelines for Isolation Precautions in Healthcare Settings, June 2007. (Downloaded 7/5/07)

Department of Health and Human Services, Centers for Disease Control and Prevention, "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings", MMWR, December 30, 2005, Vol. 54 No. RR-17

Maxair, CAPR Owner's Manual, training DVD.

III. POLICY:

Employees who have facial hair in the mask fit area may not use a N95 respirator and must use a CAPR when providing care to patients in Airborne Precautions.

Employees who cannot be fit tested or achieve an appropriate fit with the N95 respirator will also be required to use a CAPR when providing care to patients in Airborne Precautions.

When an Airborne Transmissible Disease is suspected, all persons in the room where an aerosol generating procedure (e.g., bronchoscopy, etc.) is being performed will wear a Controlled Air Purifying Respirator (CAPR).

When supplies of N95 respirators are low, the hospital may move to expand the use of CAPRs to patient care areas. Additionally, in any situation where a higher level of respiratory protection is needed, hospital administration may elect to move to the use of a

Controlled Air Purifying Respirator (CAPR). In an emergency, PAPRs may be used in addition to CAPRs

No fit testing is required to use a CAPR. Education and check-off are required.

IV. AUTHORITY/RESPONSIBILITY:

CCRMC personnel
Cardiopulmonary Personnel
Infection Prevention and Control Committee
Infection Prevention and control Program
Hospital and Health Center Administration

V. PROCEDURE:

A. OBTAINING AND USING A CAPR

1. Any employee with facial hair or who cannot wear a N95 respirator will utilize a CAPR when entering the room of a patient in Airborne Precautions.

2. CAPR and supply locations:
    a. Individual Nursing Units
    b. Detention – check with NPM or Charge nurse
    c. Ambulatory Care-Clinic charge nurse or CSM
    d. RT Department 3rd floor CCRMC

3. The CAPR will be used as follows:
    - The employee will place a surgical cap over his/her hair before donning the CAPR.
    - If Universal masking (masks required at all times while working) or masking if not immunized against influenza – the employee should wear a standard surgical mask while wearing the CAPR
    - CAPR donning and doffing reminders will be posted outside of the negative pressure airborne isolation room.
    - The employee will inspect the CAPR prior to use to verify that it is complete and functioning properly.
        - If soiled replace the front comfort band
        - Attach the disposable lens cover (DLC) prior to using the CAPR. The assembled device may be used for their entire shift.
        - Remove the Battery from the charger and attach to the CAPR unit.
            - Check lights to determine battery life and proper operation
    - At the end of the shift, the employee will remove and dispose of the lens cover and front comfort band. The surgical cap, lens cover and front comfort band should be discarded in the trash.

- The plastic helmet, battery and cable will be wiped with a disinfectant wipe before being placed on shelf/counter for storage.
- Attach the battery to the charging unit.
- If there is a shortage of the lens covers (DLC), the employee may use the same lens cover for their entire shift – should be wiped down with disinfectant wipe.

B. FILTER CHANGE AND BATTERY CHARGING

1. The Bio Medical Engineering Department is responsible for changing the filters and rotating the batteries.
    - Filters will be changed when indicated by light on the CAPR
    - Batteries will be rotated to ensure that they are appropriately discharged/charged

C. EMPLOYEE EDUCATION

1. Employees who are required to use a CAPR will be educated in its use.
    - Education and Skills Check-up will be performed annually
    - Education will be via E learning. Check-off is in person

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APPROVED:
Patient Care Policy & Evaluation Committee: 09/2017

REVIEWED: 07/2017, 5/21, 2/22

REVISED: 7/2017, 5/21, 2/22

CONTRA COSTA REGIONAL MEDICAL CENTER
CONTRA COSTA HEALTH CENTERS

Attachment A

Diseases/Pathogens Requiring Airborne Infection Isolation

- Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease (Anthrax/*Bacillus anthracis)*
- Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
- Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses; disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out.
- Measles (rubeola)/Measles virus
- Monkeypox/Monkeypox virus
- Novel or unknown pathogens
- Severe acute respiratory syndrome (SARS)
    - SARS
    - MERS
    - COVID19
- Smallpox (Variola)
- Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
- Any other disease for which public health guidelines recommend airborne infection isolation

High hazard procedures.

Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens.

Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

CODE BLUE COVERAGE FOR MARTINEZ CAMPUS

I. PURPOSE:

To provide the necessary personnel and medical equipment needed in the event of a sudden or imminent life-threatening occurrence (Code Blue) in a patient or other person(s) present in the Contra Costa Regional Medical Center hospital , Martinez Health Infusion Clinic and Mobile CT trailer

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If a Code Blue occurs in the remaining Martinez Health Center clinics or outside the main hospital building, **staff will call "9-911**" from any county phone **and provide BLS until EMS arrives (call 911 from the outside).**

To establish an organized Code Blue team that will attempt to restore adequate respiratory, hemodynamic, and neurologic function by providing basic (BLS) and advanced cardiac life support (ACLS) interventions.

II. REFERENCES:

Joint Commission on Accreditation and Healthcare Organizations Manual PC.9.30

, American Heart Association (AHA), 2020, *Advanced Cardiac Life Support Provider Manual*. Dallas, TX: AHA.

CCRMC/HCs Nursing Policy & Procedure Manual: Policy No. 201-CPR for Adults, Child and Infant; No. 204 – Code Blue Crash Cart Check; No. 206-Defibrilator, Directions for Testing and Use; No. 207-Crash Cart Exchange Program; No. 435 – Emergency Airway Support; No. 503 – Patient Expiration Policy

CCRMC Infection Control Manual, Section 400 – Employee Health

TJC PC.02.01.11, PC.02.01.20, PI.01.01.01, & PI.03.01.01 Standards for Resuscitation

III. POLICY:

All medical and direct care personnel will promptly recognize a life-threatening problem and provide BLS until the Code Blue or EMS personnel can assume care. For Code Blue in the Emergency Department See Policy #364 attachment A.

IV. AUTHORITY/RESPONSIBILITY:

The Code Blue Team is comprised of the following members:

1. MD Team Leader (one of the following):
   a. The Emergency Department (ED) Physician will be the Team Leader for Code Blues occurring throughout the hospital and Martinez Health Center Infusion Clinic, CT trailer with exception of the Operating Rooms (OR) and Post-Anesthesia Care Unit (PACU).
   b. In certain situations, the Hospitalist Physician - may support or take over from the ED Physician if there is verbal, explicit, eye-to-eye handoff.
   c. In the OR and PACU departments, the Anesthesiologist will run Code Blues unless the situation requires them to focus on the Airway. In those circumstances, the Anesthesiologist may delegate the role of MD team leader to the ED Physician with a verbal, explicit, eye-to-eye handoff.
2. Nurse Team Leader: Emergency Department (ED) RN

3. Medication Nurse: Intensive Care Unit (ICU) Charge Nurse
4. Recorder: 5D Floor RN
5. Compressor: 4B Floor RN/LVN
6. Respiratory Care Practitioner (RCP)
7. Medical Center Nursing Supervisor (MCS)
8. Nurse Program Manager (NPM) (Monday – Friday 0800 -1630).

V. PROCEDURE:

A. Staff will activate Code Blue by pressing wall Code Blue button (if applicable), or dialing "111" on any Martinez campus official county telephone to alert the operator to broadcast overhead announcement with the location and room number.

B. If Code Blue happen in Mobile CT trailer. Staff will call "111" for hospital Code Team and "911" for EMS

C. Upon notification of Code Blue the Operator will:
   - Activate an alert tone of three beeps and overhead announce "Code Blue," stating the exact location and the room number.
   - Repeat the announcement three times in succession. The announcement is repeated approximately 10 – 15 seconds after the initial call until the Code Blue is secured or cancelled.

D. If a Code Blue occurs in a locked unit or floor, see below:
   - If Code Blue occurs in the Operating Room (OR), the OR Charge Nurse will assign a person to be at the locked stairwell door to admit code team.

   Essential Code Blue Team members will NOT delay arrival (or be detained) for sterility concerns.
   - If Code Blue occurs in either of the locked psychiatric units, the Psychiatric Charge Nurse will assign a person to be at the locked door to admit the code team.
   - After hours the Medical Center Supervisor will ensure access to the locked locations.

E. Crash Carts with a defibrillator will be located in each patient care area as follows: ED third floor, Diagnostic Imaging, CT Trailer, Infusion Clinic, CCU, IMCU, Telemetry (4A), Medical Surgical (4B & 5D), Inpatient Psychiatry (4C &4D), - Psychiatric Emergency (3C), Labor and Delivery (5A), Postpartum (5C), in both Operating Room Areas on the 2nd and 5th Floors and Post Anesthesia Recovery Room (2C).
   Pediatric Color Coded Crash Carts will be located in the Emergency Department, Psychiatric Emergency, Diagnostic Imaging, CT trailer, - -
   Neonatal Crash Carts are located in the Nursery (5B), Labor and Delivery (5A) and in the 5th floor Operating room area.

F. After Initial Code Blue activation, staff will dial 111 to "Secure Code" ONLY when all Team Members have arrived, or to "Cancel Code" if Code was initiated accidentally.

G. Anesthesia will be overhead and beeper paged STAT for airway emergencies. Any anesthesiologist in-house will respond when available. Anesthesia will focus on airway securement. Apart from the OR/PACU, they will not serve as Code Blue MD Team Leader but rather as delegated by MD Team Leader.

H. Roles and Responsibilities:

At the beginning of each shift, the Nursing Office and Emergency Department (ED) will assign nursing and medical staff, respectively, to respond to Code Blue. A plan to relieve code members of their unit assignments for the duration of the code will also be established by the Charge Nurse at the beginning of each shift.

A team approach must be established and systematically followed by **all** healthcare staff involved in responding to Code Blues. All members of the code team are expected to identify themselves and their role upon arrival.

- The ED MD will respond to **ALL codes in the hospital regardless of the time of day.** The ED MD will lead all codes, with the exception of Anesthesia running codes in the OR/PACU (as stated above) unless otherwise requested.
- The ED MD can relinquish the responsibility of running a code to an experienced Hospitalist Physician if handoff is explicitly verbalized and agreed upon with a statement such as, "I am Dr. 'X' and I will be running this code."

Initial Responder Responsibility		
Personnel	Required Competency	Responsibilities
Initial Responder (s)	BLS	• Calls for help, activate Code Blue by pushing Code Blue button or dialing 111. • Initiates BLS algorithms • Brings Crash Cart • Brings anesthesia airway kit from the Omnicell, as soon as possible • Places Backboard from back of crash cart under patient • Places AED Pads on patient and turns on the defibrillator to AED mode.
Code Blue Team Member Responsibilities		
MD Team Leader • ED Physician • Hospitalist Attending (if there is a verbal, explicit, eye-to-eye handoff from ED Physician) • Anesthesiologist in OR/PACU (with exceptions if airway focus requires delegation of leadership role as stated above)	ACLS	• States "I am Dr. X and I will be running this code. • Directs and Coordinates the Code sequence • Coordinates the Code Team • Discourages any intervention which results in interruptions of CPR • Orders medications during the Code • Ends the Code when appropriate • Summarize the events and the final status in the Medical Record • Collaborates with MCS to conduct debriefing session with Team and to arrange communication with family. • Delegates necessary procedures (e.g.,

		intubation, compressions, intra-osseous catheter placement) to other team members.
Residents cont'd.	ACLS	• Under direct supervision of Attending Physician Team Leader. • Can function as Co-Team Leader if explicitly verbalized. • Can assist with procedures such as intubation or intra-osseous catheter placement (with supervision). • Can assist with compressions and forming compressor line. • Can assist with family communication.
Nurse Team Leader ED RN	ACLS	• Assists Physician Team Leader with procedural flow of Code • Manages Defibrillator and rhythm strips • Collects data, verbalizes vital signs, including rhythms, to MD and recorder. • Keeps track of Code Sequence. • Facilitates identification of members of the code team: MD Team Leader, Medication Nurse, Recorder and themselves. • Coordinates with MCS to Secure Code once all team members have arrived. • Assists with other duties as required, including providing Respiratory Care Practitioner with end-tidal CO2 tubing and monitor.
Medication Nurse ICU Charge Nurse or ICU Relief Charge Nurse	ACLS	• Obtains IV access as required • Administers Medication and communicates medication administration to MD team leader and recorder • Ensures the set up of Lines and Drips with required labels
Recorder Floor RN	BLS	• Identifies self on arrival and physically positions self alongside the MD Team Leader and Nurse Team Leader to facilitate effective communication of Code sequence and updates during the Code Blue. • Maintains written record of Code sequence. • Serves as Code time keeper and notifies team of 2 minute intervals.

		• Completes Code Blue under supervision of Nursing and Physician Team Leaders
Compressor Floor Nurse (RN/LVN)	BLS	• Performs chest compressions as required • Coordinates rotation of compressors every 2 minutes to ensure high quality CPR • Sets up compressor line (either on periphery of room or outside the room) in order to facilitate transitions between compressors
Respiratory Care Practitioner	ACLS	• Assist with airway establishment and maintenance • Provides artificial ventilation and supplemental oxygen as needed • Established end-tidal CO2 monitoring and secures it to patient
Medical Center Supervisor(MCS)/Nurse Program Manager (NPM) MCS/NPM cont'd.	ACLS	• Liaison between Hospital and Patient's family. Will arrange social support for family members who desire to bear witness to code blue. Will provide contact information for family who are not present. • Ensures distribution of needed personal protective equipment to Code Blue team members who may be at risk of body fluid exposure. • Arranges for additional coverage in the event of simultaneous Code Blues. • Assigns a runner and/or other resources as needed. • Coordinates with Nurse and MD team leader to confirm all Code Team members are present and call Code Secure to operator. • Ensures code blue debriefing occurs. • Completes Code Blue Critique Form after EVERY Code Blue. • Takes responsibility for yellow Code Blue record copy. • Arranges for ICU bed as appropriate.

I. Post-Resuscitation Care Responsibilities:
   1. After Return of Spontaneous Circulation (ROSC), the Code Blue Team is Responsible for providing intensive care and monitoring the patient until:
      a. Patient is transported to the next level of care

b. Patient is stable and the care is officially turned over to the patient's primary physician and nurse.

2. MD Team Leader:
   a. Remains at patient's bedside and accompanies patient to the next level of care or **ensures delegation** of responsibility to appropriate party.
   b. Reassesses patient's condition, orders/obtains labs if appropriate, arranges for appropriate invasive lines/tubes to be placed.
   c. Requests or provides expert consultation to determine if patient meets criteria for post-cardiac arrest therapeutic hypothermia, and if so, arranges for orders to be entered into ccLink and cooling to be started at the bedside.
   d. Writes "Code Documentation" note in patient's medical record in ccLink.
   e. Ensures that family has been contacted and that a physician will be available to speak to them upon their arrival.
3. Recorder
   a. Ensures that all required documentation is completed accurately with required signatures.
   b. Ensures that rhythm strips are attached to the back of the original Code Blue record and submitted to Medical Center Supervisor.
4. Medical Center Supervisor/Nursing Program Manager
   a. Ensures that Code Blue Critique Form is completed and submitted appropriately for Quality Review.
   b. Requests for rapid debriefing (if not already performed).

J. In the event of death:
   1. MD Team Leader will pronounce death and write Code Documentation note in the patient's medical record in ccLink.
   2. MD Team Leader (or designee) informs patient's family as soon as possible in a quiet, private area. The physician will inform family of the circumstances and cause of death, if known.
   3. Nursing personnel will prepare patient for family visit.
   4. Nursing Program Manager or Medical Center Supervisor will notify chaplain at family's request (if not already present), and support family and nursing staff. See Patient Expiration Policy #503 and Post-Mortem Care Policy #310.

K. Quality Review: Ongoing review of outcomes regarding resuscitation will be discussed at the Code Blue Committee Meetings.

L. Periodic Education and Training includes resuscitation procedures , protocol , equipment, roles and responsibility are provided to staff

VI. FORMS:

Code Documentation Note in ccLink
Code Blue Record MR 201 - 8
Code Blue Critique Form (A-601)

VII. ATTACHMENTS

364-A Code Blue in emergency department
364-B Code Blue Critique form

364-C Protected Code Blue (Code Blue during COVID19 Pandemic)
364-D Code Blue Record
364-E Physician on scene
364-F Code Blue Workflow in PES

VIII. RESPONSIBLE STAFF PERSON:

Chair of the Code Blue Subcommittee
Chair of the Critical Care Committee

Reviewed/Revised: 8/99, 9/03,2/03.2/04, 11/10, 9/13, 05/14, 3/2018, 7/2020, 8/2021, 2/2022

APPROVED BY:

Code Blue Committee 9/13, 3/2018, 8/2021
Critical Care Committee 9/13, 2/2022
Clinical Practice Committee 7/2020, 9/2021, 2/2022
Patient Care Policy & Evaluation Committee 8/2020, 9/2021, 3/2022
Medical Executive Committee 9/2020, 9/2021, 4/2022

PROTECTED CODE BLUE
(Code Blue during COVID19 Pandemic)

I. PURPOSE:

To supplement current Code Blue Policy during COVID-19 pandemic. To guide the Code Blue team that will attempt to restore adequate respiratory, hemodynamic, and neurologic function by providing basic (BLS) and advanced cardiac life support (ACLS) interventions. To establish the preferred medical equipment and Personal Protected Equipment (PPE) needed in the event of a sudden or imminent life-threatening occurrence (Code Blue) during the COVID-19 Pandemic in Contra Costa Regional Medical Center, Martinez Health Infusion Clinic and Mobile CT scan trailer during COVID-19 pandemic. If a Code Blue occurs in the remaining Martinez Health Center clinics or outside the main hospital building, **staff will call "9-911**" from any county phone **and provide BLS until EMS arrives (call 911 from the outside).**

II. REFERENCES:

AHA ACLS, PALs, And NRP Interim Guidance for Basic and Advanced Life Support in Adults, Children, and Neonates with Suspected or Confirmed COVID-19
Kaiser Permanente Northern California Mitigation Phase Playbook Coronavirus Disease 2019 (COVID-19)
Consensus statement: Safe Airway Society principles of airway management and tracheal intubation specific to the COVID-19 adult patient group. DJ Brewster, NC Chrimes, TBT Do, K Fraser
https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.120.006779
Cardiopulmonary resuscitation during the COVID-19 pandemic: Maintaining provider and patient safety. B Sen-Crowe, M Sutherland, M McKenney, A Elkbuli. Am J Emerg Med 2020 Oct 15.

III. POLICY:

To safely manage patients with sudden cardiac arrest during the COVID-19 pandemic while protecting staff with proper PPE use.

IV. AUTHORITY/RESPONSIBILITY:

Hospital and Health Services Medical Director
Director Inpatient Nursing Operations
Code Blue Committee
Code Blue Team
Infection Control

V. PROCEDURE:

A. Personal Protective Equipment (PPE – as defined in this section, referred to as "PPE" through the remainder of this document**)**

a. Intubating team members (Physician Airway Manager and RT) should wear CAPRs
b. Anyone entering the patient's room must have donned appropriate PPE prior to entry (gloves, N95 or equivalent, eye shield; gowns are optional)

c. PPE are located in the bottom drawer of the adult crash cart include: 9 yellow gowns, 9 "goggles"/eye shields, 9 of each size of N95 mask, 1 clear plastic drape as optional protection
d. If patient transport is required after Return of spontaneous circulation (ROSC), appropriate PPE must also be worn in case rapid intervention is needed

B. The Code Blue Team Member Responsibilities:

INSIDE THE ROOM		
Personnel	**Required Competency**	**Responsibilities**
1st Responder	BLS	1. Confirms unresponsiveness. Checks for central pulse. 2. Calls for help 3. Dons PPE and role sticker 4. Applies NRB @15L/min and pulls sheet over patient's head. Does not bag valve mask until further instruction from airway physician. 5. Lays plastic drape over the patient's shoulder, neck, and face 6. Commences CPR 7. Places patient on cardiac monitor if available once 2nd responder takes over compressions. 8. Alternates compressions with 2nd responder and compressor 9. Gives report to Physician Team Lead and Code Team 10. Once Lucas is running, becomes the runner between inside and outside teams.
2nd Responder	BLS	1. Brings crash cart and leaves outside room 2. Dons PPE and role sticker 3. Brings in backboard, defibrillator, and defibrillator pads 4. Places backboard under patient 5. Places defibrillator at foot of bed, applies defibrillator pads and set to AED mode 6. Delivers shock if advised 7. Alternates compressions with first Responder and other available compressors inside the room as needed. 8. Doffs and leaves room once Lucas is running 9. Becomes the outside runner (retrieves items not on crash cart)
RN Team Lead	ACLS	1. Brings Lucas device to code 2. Dons PPE and role sticker 3. Places Lucas device on patient during pulse check 4. Manages Lucas
Medication RN	ACLS	1. Brings 2 CAPR bags to code 2. Dons PPE and role sticker 3. Verifies IV access/Obtains IV access 4. Manages defibrillator 5. Administers Meds
Recorder	BLS	1. Dons PPE and role sticker 2. Records events and keeps time

		3. Calls out 2-minute intervals for Pulse and Rhythm checks 4. Double checks documentation after code with RN Team Lead and Physician Team Lead
Compressor / Doffing Observer	BLS	1. Dons PPE only if third compressor needed. a) Alternates compressions with 1st and 2nd responders b) Doffs and leaves the room once LUCAS running 2. Observes Staff Doffing PPE 3. Ensures transport team changes gown and gloves prior to transport
PHYSICIAN TEAM LEAD (First experienced physician)	ACLS	1. Dons PPEand CAPR only if will also be intubating physician 2. Changes defibrillator to monitor mode. 3. Runs code 4. Places IO as needed 5. Double checks documentation with Recorder and RN Team Lead
AIRWAY PHYSICIAN (ED PHYSICIAN or most experienced airway physician)	ACLS	1. Brings CAPR bag to code blue, Butterfly US if desired 2. Dons PPE and CAPR 3. Prepares Glidescope 4. Reminds team to pause compressions and step back from patient immediately before intubating. 5. Once airway system is sealed, orders resume compressions. 6. Verifies tube location 7. Ensures ETT is clamped before switching to ventilator 8. Airway physician can consider bag valve mask a) RT to assemble ambu bag, PEEP valve (if applicable), viral filter, EtCO2 b) Strict two-handed mask technique must be used to avoid air escaping from mask into the environment of care 9. Once advance airway established, work to maintain closed circuit to minimize aerosolization
1st RT	ACLS	1. Dons PPE and CAPR 2. Sets up ETCO2 monitoring (for pre and post-intubation) 3. Sets up suction 4. Puts stylet in ETT 5. Receives assembled BVM from 2nd RT/inside runner and checks viral filter 6. Assists Airway Physician with intubation 7. Assists Airway Physician with 2 handed hold of BVM if needed 8. Clamps ETT if patient must be disconnected 9. Places patient on ventilator
OUTSIDE THE ROOM		
Unit Charge Nurse	BLS/ACLS	1. Designate unit clerk or other staff to call operator 111 2. Dons surgical mask and gloves 3. Manages crash cart - pass medications and supplies from crash cart to inside runner 4. Hands out PPE and role stickers, assists in donning
2nd RT	ACLS	1. Helps set up / obtain equipment for RT inside the room 2. Dons surgical mask and gloves
Outside	ACLS	1. Dons surgical mask and gloves with appropriate additional PPE

Physician Team Leader		ready if presence needed inside room 2. Assists and coordinates activities outside of the room, and leads post code debriefing 3. If there is a delay in Lucas delivery, then outside physician leader or MCS/NPM assigns 2 additional compression staff to don PPE and enter room to rotate as compressor
Medical Center Supervisor or Nurse Program Manager	ACLS	1. Establishes communication between outside team and inside team, crowd and noise control, assist with notifying family. 2. Secures code blue once verified that all team are present. Assigns unit clerk or staff to call operator to secure code blue. 3. Calls for debriefing after the code.
RRT Nurse	ACLS	Brings Glidescope and hands off to Outside Physician Team Lead

C. Post Code

a. Follow appropriate Infection Control Policies
b. Consider typical post ROSC medical procedures
c. Perform debriefing in an area that may permit physical distancing

D. Continuous Readiness - At the Beginning of Each Shift

a. 4B charge nurse will assign appropriately trained nurse compressor
b. 5D charge nurse will assign appropriately trained nurse recorder
c. ICU/Med RN will verify they have intubating physician and RT equipment in bag ready to bring to code blue:
   - 2 CAPRs + 4 shields/cuffs of each size
   - 2 charged battery packs (plug into helmet to confirm)
   - 2 bouffants (if available)
d. ER Code RN will confirm availability / functionality of Lucas Compression Device
   - Staff bringing equipment to code blue may need to use elevator given size/weight of the devices

VI. FORMS:

Code Documentation Note in ccLink
Code Blue Record MR 201 8
Code Blue Critique Form (A-601)

VII. ATTACHMENTS

364-A Code Blue in emergency department
364-B Code Blue Critique form
364-C Protected Code Blue (Code Blue during COVID19 Pandemic)
364-D Code Blue Record
364-E Physician on scene

VIII. RESPONSIBLE STAFF PERSON:

Chair of the Code Blue Subcommittee
Chair of the Critical Care Committee

Reviewed/Revised: 4/2020, 2/2022

APPROVED BY:
Code Blue Committee:
Critical Care Committee: 2/2022
Clinical Practice Committee: 2/2022
Patient Care Policy & Evaluation Committee: 9/2020, 3/2022
Medical Executive Committee:9/2020, 4/2022

CODE BLUE WORKFLOW in PES

Personnel	Responsibilities
Responder 1	Call help
Staff on the unit	Dial 111
Responder 2	Bring Crash Cart & Comfort Glide inflatable Hover mat 40'' x 80" from the clean utility room
Responder 1 & 2 or Charge Nurse	Slide patient to the floor (2 persons) if applicable
Responder 1	Perform CPR
Responder 2	Apply defibrillator pads and turn the knob to AED
Responder 2	Bring O2 tank, apply NRM with 100% O2: (BVM for COVID negative patient at 30:2)
Responder 2	Perform defibrillation when prompted for VT or V. Fib
Responder 1 & 2, Code Team	Put Comfort Glide under the patient during 10 sec. pulse check, **do not inflate the Hover mat**
Responder 1 & 2	Continue CPR for 5 cycles, provide SBAR to physician code team lead
Charge Nurse, or designee	Bring the -gurney to the hallway
Code Team Members	Move patient to hallway during 10 sec pulse check
Code Team Members	Lower the -gurney to the lowest level, utilize comfort glide to lift patient up to the stretcher
Code Team Members	Raise the -gurney, transfer patient to ED & Perform CPR on route
Code Team Members	Secure all devices and patient
Charge Nurse	Open doors for patient transport, ensure no PES patients AWOL
Code Team Members	Transfer patient from stretcher to ED gurney

Note:
NRM – non-rebreather mask
BVM – bag valve mask
Review 5/19/2021, 2/9/2022

INPATIENT PSYCHIATRY PSYCHOLOGICAL TESTING

I. PURPOSE:

To provide guidelines for the neuro-psychological testing needs of patients on the Inpatient Psychiatric Service.

II. REFERENCES:

TJC 2021 Standards: PC.02.01.05.
Title 22: Section 71205.

III. POLICY:

Patients hospitalized on an Inpatient Psychiatry Unit may receive neuro-psychological testing by a psychologist if the attending psychiatrist determines that it is necessary.

IV. AUTHORITY/RESPONSIBILITY:

Psychiatry Chief(s), Psychiatrists, Nursing Program Managers (NPMs), Nursing Staff, Mental Health Clinical Specialist/Medical Social Worker (MHCS/SW)

V. PROCEDURE:

A. On site neuro-psychological testing is requested by the attending psychiatrist.
   1.
B. The attending psychiatrist uses these guidelines to determine if Neuro-Psychological testing may be helpful:
   1. Patient diagnosis is uncertain.

   2. Patient remains confused, delusional, violent or regressed, and demonstrates no improvement. Patient demonstrates no significant improvement with medication.

C. The coordination of the testing is arranged by the MHCS or SW and communicated to the Charge Nurse.

D. Within one (1) day of completing neuro-psychological testing, the testing psychologist will contact the attending physician with a verbal report of their findings.

E. A written report by the psychologist is sent to the attending psychiatrist. Or when feasible, a consulting note is completed in the Electronic Medical Record.

DOCUMENTATION:

Patient Care Record in ccLink

APPROVED BY:

Clinical Practice Committee 1/2018, 2/2022
Patient Care Policy & Evaluation Committee 3/2022
Medical Executive Committee 4/2022

CODE GRAY AND ASSISTANCE CALLS

I. PURPOSE:

Provide guidelines for Code Gray and Assist Team calls throughout the Hospital in order to safely manage patients with behavioral escalations or emergencies.

II. POLICY:

Code Gray calls are requests to manage escalating patient behavior that can be considered an emergent threat to the safety of the patient and/or others.

Assist calls are non-emergent requests to assist managing patients with challenging behavioral issues.

The Team members who respond to these calls are certified in safe de-escalation and take-down techniques by the Crisis Prevention Institute (CPI). Team members are scheduled to respond to calls during the shifts they work in their primary roles. Team members receive additional pay from the County for this work.

All staff at CCRMC complete annual workplace safety training to recognize the early signs of escalating behavior, and to take appropriate steps to prevent or mitigate workplace violence. All nursing staff at CCRMC must also complete required C.P.I. training for their department and role to safely manage aggressive or escalating behavior and behavioral emergencies.

III. AUTHORITY/RESPONSIBILITY:

Psychiatry Chief(s), Director of Inpatient Nursing Operations, Nursing Program Managers (NPMs), Medical Center Supervisor(s), Code Grey/Assist Team members, Hospital Security Chief, Hospital Security Officers, Nursing Staff, Psychiatrists and other Physicians, Social Services Staff, Clerks, Hospital Telephone Operators.

IV. PROCEDURE:

A. Calls to request Code Gray Response:

1. These calls are made for behavioral emergencies such as:
   a. Behavior that is threatening to self or others.
   b. A patient on a legal hold actively leaving the specific unit.
   c. A patient who is assaultive / highly agitated and requires a hold for emergency medications for agitation and/or requires restraints and/or seclusion.

2. How to call: Dial "333" and state to the operator, "Code Gray Team to the specified unit (or specific location in the hospital)"

3. The Code Gray response team:
   a. Consists of a minimum of 5 staff members.
3. The team will consist of a minimum of 3 clinical staff members.
   b. To be on the team, members have to be available to respond to the calls for the entirety of their shift.

4.The operator will overhead call the Code Gray Team and notify Hospital Security as well as group page the Code Gray Team. The operator will continue to overhead page until a staff member from the unit calls the operator to say the code is either canceled or secured.

5. The charge nurse or the primary nurse of the receiving unit will direct the team to the location where the Code Gray responses needed.

B. Calls to request the Assist team:

1. These calls may be made for non-emergent needs for assistance with patients with escalating or challenging behaviors such as:.

a. Giving medications to patients that have challenging behaviors.

b. Setting limits for challenging behaviors.

c. Transporting patients that have challenging behaviors.

d. Applying or Changing restraints if a patient is not an imminent threat to the safety of self or others.

2. How to Call: Dial "333" and state to the operator, "Assist Team to the specified unit (or specific location in the hospital)."

3. The Assist Team:

a. Consists of a minimum of 5 staff members, including at least 3 clinical staff.

b. To be on the team, members must be available to respond to the calls for the entirety of their shift.

4. The operator will group page the Assist Team **and** will only overhead call as well if the team is **not** complete (per the Assist Team staffing assignments for that day). The operator will overhead call "All Trained Assist Team" to respond to that particular unit/location until a staff member from the unit/location calls the operator to say the code is either canceled or secured.

5. The charge nurse or primary nurse in the receiving unit will direct the team to the location where the Assist Team response is needed.

C. Code Gray/ Assist Team Members and Unit Staff agree on these safety guidelines:

. 1. In the event where the team applies physical interventions they will use safety training principles learned from the Crisis Prevention Institute (CPI) training that is required for all nursing staff and Code Gray/Assist Team members.

2. The primary nurse or designee of the receiving unit is to monitor the patient's respiratory status during physical intervention.

3. The nurse may halt the intervention any time he/she assesses the patient to be having respiratory status compromised.

3. The patient's primary nurse and/or charge nurse is to direct the clinical care of the patient. Discuss the necessary medical precautions, provide relevant history, and offer support as needed throughout the call.

4. Primary nurse will document care during physical intervention in patients' medical record.

D. Code Gray /Assist Team responsibilities:

1. Code Gray and/or assist team members will report to the unit in a timely manner.
2. Immediately stop what you are doing and walk purposefully and swiftly to the designated area of the call.
3. Follow safety training principles (CPI).
4. Follow Standard Precautions.
5. Document any unusual occurrences in safety event reporting system (SERS) and inform your manager and/or medical center supervisor.

E. Code Gray- Team Captain: whether "Assist" or "Code Gray," the captain directs the team throughout the call.

1. The captain conducts the debriefing of the incident.
2. Captain completes the critique form and turns it in to the designated staff member who collects these forms and enters the information into a database.
3. The code gray team captain announces when the team is cleared to return to regular duty.

F. Hospital Security Officer Role in Code Gray/Assist Calls:
Hospital Security Officers **are not members of the Assist/Code Gray Team**.

Assist Calls: Hospital Security Officers are **not expected to** respond to Assist Team calls.

Code Gray Calls: Hospital Security Officers receive communication about Code Gray calls via overhead page and two-way radio (either from the Hospital Operator or from the Unit Charge Nurse). If not occupied with another priority security issue, they will respond to Code Gray calls to be on standby. Hospital Security Officers may take over the lead from the Captain of the Code Gray team by request from the Team Captain, for example in the event of an imminent threat to the safety of patients, staff, providers, or visitors on the unit.

V. DOCUMENTATION:

Patient Care Record - ccLink
Code Gray and Assist Critique Form

APPROVED BY:

Clinical Practice Committee 1/2018, 2/2022
Patient Care Policy & Evaluation Committee 3/2022
Medical Executive Committee 4/2022

Reviewed: 3/99, 9/99, 9/03, 8/06, 8/09, 7/11, 10/17, 4/18
Revised: 3/99, 9/99, 9/03, 8/06, 8/09, 7/11, 10/17, 4/18, 02/22

DIRECT ADMISSIONS TO CONTRA COSTA REGIONAL MEDICAL CENTER (CCRMC)

I. PURPOSE:

To outline the correct procedure for directly admitting patients from an ambulatory care health center to CCRMC.

II. REFERENCES:

CCRMC Policy #552, "Accepting Patient Transfers from Outside Facilities."

TJC 2020 Standard PC.02.01.01, "The hospital provides care, treatment and services for each patient."

III. POLICY:

All direct admissions to the medical/surgical units must be medically accepted by the Medical Officer of the Day at CCRMC and must be cleared for resource availability by calling pager 346-4243. This must occur prior to transport. The patient should not be sent to CCRMC without final approval of the Medical Center Supervisor and the Medical Officer of the Day. If direct admission is accepted, patient shall be sent directly to the appropriate inpatient unit.

IV. AUTHORITY/RESPONSIBILITY:

All nursing personnel and Providers

V. PROCEDURE:

A. Once the decision that a direct admission to CCRMC may be necessary, the Health Center provider will do the following:
   1. Patients considered appropriate for direct admission to CCRMC must be discussed with and approved for admission by the inpatient Medical Officer of the Day prior to transfer.
   2. If the direct admission is accepted, the Medical Officer of the Day will contact the Medical Center Supervisor to confirm bed availability for the recommended level of care. The Medical Center Supervisor will then coordinate the next steps for the patient's admission with the patient's current care team in clinic.

B. The Medical Center Supervisor will:
   1. Assign the patient to the appropriate unit/bed.
   2. Inform receiving inpatient unit.
   3. Call clinic where patient is being directly admitted from to assure the following:
      a. Confirm that resources are available, and that direct admission is accepted,
      b. Provide information on admitting unit/bed, and to confirm that clinic nurse will call the inpatient unit nurse with clinical information about the patient,
      c. Confirm estimated time of arrival.

4. Inform admitting office.

C. Clinic Nurse will:

1. Receive a call from the Medical Center Supervisor as outlined in Section B above. If Medical Center Supervisor does not call the clinic nurse shortly after the transferring physician called the accepting physician, clinic nurse should call Staffing Office (370-5132). The patient should not be sent to CCRMC without final approval of Medical Center Supervisor.
2. Call the inpatient unit nurse and report on the care provided at the clinic and the estimated time of arrival of the patient.
3. Complete documentation in ccLink.
4. Give patient (if transportation is by private car) or ambulance attendant the "Patient Information Handbook" [A-543-9], and instructions as to which in-patient unit the patient should go. If family is available, they should be instructed to go to Admissions at CCRMC to admit the patient. If the family is not available, the admissions' clerk will go to the nursing unit to obtain necessary admission information.
   - Give ambulance staff a copy of the patient's face sheet for patients being transported to the hospital by ambulance.
5. General Guidelines
   a. Patients potentially needing surgery should remain NPO.
   b. Patients suspected of having a contagious respiratory condition should be given a mask and instructed to wear it.
   c. Patients shall be determined to be stable prior to transfer. Mode of transportation to the hospital to be determined by the medical provider.
   d. Patients felt to be stable who become unstable en route will be evaluated in the Emergency Department upon arrival.
   e. In some cases, referral to the Emergency Department is appropriate to determine need for admission. The on-duty Emergency Department physician shall be consulted prior to referral. (See Policy #3055, "Referrals to Emergency Department from Regional Health Centers")

REVIEWED, REVISED AND APPROVED BY ACPC:
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JCC/BOARD APPROVAL: pending